

Highlights of your Health Care Coverage

City of Spokane

Group Number: 1018813

Effective Date: 01/01/2024

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

| MEDICAL PLAN | | |
|---|---|---|
| | CITY PLAN 6 \$20/\$40 RX PLAN HERITAGE | |
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| MEDICAL COST SHARE OPTIONS | | |
| Individual Deductible PCY (Family embedded deductible 3X Individual) | \$750 | Shared with In-Network |
| Coinsurance (Member's percentage of costs after deductible based on allowable charges) | 30% | 50% |
| Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 3X Individual) | \$1,500 | Unlimited |
| Office Visit Cost Share | \$30 Copay, applies to the \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| Kinwell Connect Cost Share Waiver (Included) | All services rendered and billed by any Kinwell clinic are covered in full (waive deductible, 0%) | Not Applicable |
| PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION | | |
| Preventive Office Visit (Unlimited) | Covered in Full | Not Covered |
| Immunizations (Unlimited) | Covered in Full | Not Covered |
| Health Education (HE) (Unlimited) | Covered in Full | Not Covered |
| Nicotine Dependency Programs (ND) (Unlimited) | Covered in Full | Not Covered |
| Diabetes Health Education (DE) (Unlimited) | Covered in Full | Not Covered |
| PROFESSIONAL CARE | | |
| Professional Office Visit | \$30 Copay, applies to the \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |

| MEDICAL PLAN | | CITY PLAN 6 \$20/\$40 RX PLAN HERITAGE | |
|--|---|---|--|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK | |
| Telemedicine with Traditional Providers - General Medical | \$30 Copay, applies to the \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| VIRTUAL CARE SERVICES | | | |
| Telemedicine - General Medical (Virtual Care Only) | \$30 Copay, applies to the \$1,500 Out of Pocket Maximum | Not Covered | |
| DIAGNOSTIC SERVICE OPTIONS | | | |
| Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA | Covered in Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Other Professional Diagnostic Imaging | First \$100 Covered in Full, then \$750 Deductible and 30% Coinsurance thereafter, Excludes TMJ; applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Professional Diagnostic Major Imaging | First \$100 Covered in Full, then \$750 Deductible and 30% Coinsurance thereafter, Excludes TMJ; applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Other Professional Diagnostic Laboratory/Pathology | First \$100 Covered in Full, then \$750 Deductible and 30% Coinsurance thereafter, Excludes TMJ; applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Diagnostic Mammography | Covered in Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Supplemental Breast Exam | Covered in Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| FACILITY CARE OPTIONS | | | |
| Inpatient Facility | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Inpatient Professional Services | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Outpatient Surgery Facility | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Skilled Nursing Facility (180 days PCY; includes room and board, and facility billed professional and ancillary fees) | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |

| MEDICAL PLAN | | CITY PLAN 6 \$20/\$40 RX PLAN HERITAGE | |
|---|---|---|--|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK | |
| HOSPICE & HOME HEALTH CARE | | | |
| Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum) | \$750 Deductible, then Covered in Full, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum) | \$750 Deductible, then Covered in Full, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| MATERNITY & REPRODUCTIVE CARE | | | |
| Contraceptive Management Services (Unlimited) | Covered in Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Sterilization - Female (Unlimited) | Covered in Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Sterilization - Male (Unlimited) | Covered in Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| MEDICAL TRANSPORTATION BENEFITS | | | |
| Transplant Travel & Lodging (\$7,500 per transplant) | \$750 Deductible, 0% Coinsurance, applies to \$1,500 Out of Pocket Maximum | \$750 Deductible, 0% Coinsurance, applies to \$1,500 Out of Pocket Maximum | |
| EMERGENCY CARE AND TRANSPORTATION OPTION | | | |
| Emergency Care (If applicable, waive copay if admitted to inpatient facility) | \$150 Copay then \$750 Deductible and 30% Coinsurance; all cost shares apply to the \$1,500 Out of Pocket Maximum | \$150 Copay then \$750 Deductible and 30% Coinsurance; all cost shares apply to the \$1,500 Out of Pocket Maximum | |
| Emergency Room Physician | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | |
| Urgent Care Center | \$30 Copay, applies to the \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Ambulance Transportation (Unlimited) | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | |
| ALTERNATIVE CARE | | | |
| Acupuncture (24 visits PCY) | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Manipulations (Spinal and other) (30 visits PCY) | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| CHEMICAL DEPENDENCY & MENTAL HEALTH | | | |

| MEDICAL PLAN | | CITY PLAN 6 \$20/\$40 RX PLAN HERITAGE | |
|--|--|---|--|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK | |
| Chemical Dependency Inpatient Facility Care (Unlimited) | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Chemical Dependency Outpatient Professional Care (Unlimited) | \$30 Copay, applies to the \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Mental Health Inpatient Facility Care (Unlimited) | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Mental Health Outpatient Professional Care (Unlimited) | \$30 Copay, applies to the \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| REHABILITATION & NEURO | | | |
| Rehab Inpatient Facility (30 days PCY) | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY) | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| OTHER SERVICES | | | |
| Allergy/Therapeutic Injections | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Medical Supplies, Equipment, Prosthetics (Unlimited) | \$750 Deductible, then 30% Coinsurance, applies to \$1,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Transplants (Unlimited) | Covered as any other service | Not Covered | |
| SUPPLEMENTAL BENEFITS | | | |
| Routine Vision Exam (1 PCY) | Covered in Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Vision Hardware (\$200 every 2 consecutive calendar year) | Covered in Full | Covered in Full | |
| Pediatric Vision Exam (1 PCY Under age 19) | Covered in Full | Covered in Full | |
| Pediatric Vision Hardware (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).) | Covered in Full | Covered in Full | |
| ANNUAL PLAN MAXIMUM | | | |
| Annual Plan Maximum | Unlimited | Unlimited | |

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan. This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

Highlights of your Health Care Coverage

City of Spokane

Group Number: 1018813

Effective Date: 01/01/2024

Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

| PHARMACY PLAN | |
|---|---|
| PLAN 6 RX RETAIL \$20/\$40 RETAIL: \$40/\$80 MAIL ORDER* | |
| PRESCRIPTION DRUGS | |
| Drug List | Preferred A2 Tier 1 = generic Tier 2 = brands |
| Annual Benefit Maximum | Unlimited |
| Individual Deductible PCY | \$0 |
| Family Deductible PCY | No Family Deductible |
| Out of Network (Non-participating retail pharmacies) | Cost Share, then 40% (to allowable) |
| Out of Pocket Maximum | Applies to the medical out of pocket maximum |
| Retail Cost Shares | \$20/\$40 |
| Mail Cost Shares | \$40/\$80 |
| Day Supply | Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days |

*This plan is self-funded by City of Spokane, which means that this group is financially responsible for the payment of plan benefits. The group has contracted with Premera Blue Cross, an independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties, including the processing of claims, under the plan. Premera Blue Cross does not insure the benefits of this plan.

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan. This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/online-services/cc/pub/complaintinformation.aspx>.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភ្នែកភាសា ដោយមិនគិតថ្លៃសម្រាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471 (TTY:711) まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ እማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚክሶሎ ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው፡ 711)።

XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

பிரதான சிபி: நீ துமீ பிளாசி கெலதே தே, தா தாமா கீச்ச மலாபிதா மெல துலாடே சலி ஸுடத குயலகம தே। 800-722-1471 (TTY: 711) 'தே வால வதே।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດອຸບານ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ວາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sévis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجیه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

037378 (07-01-2021)

